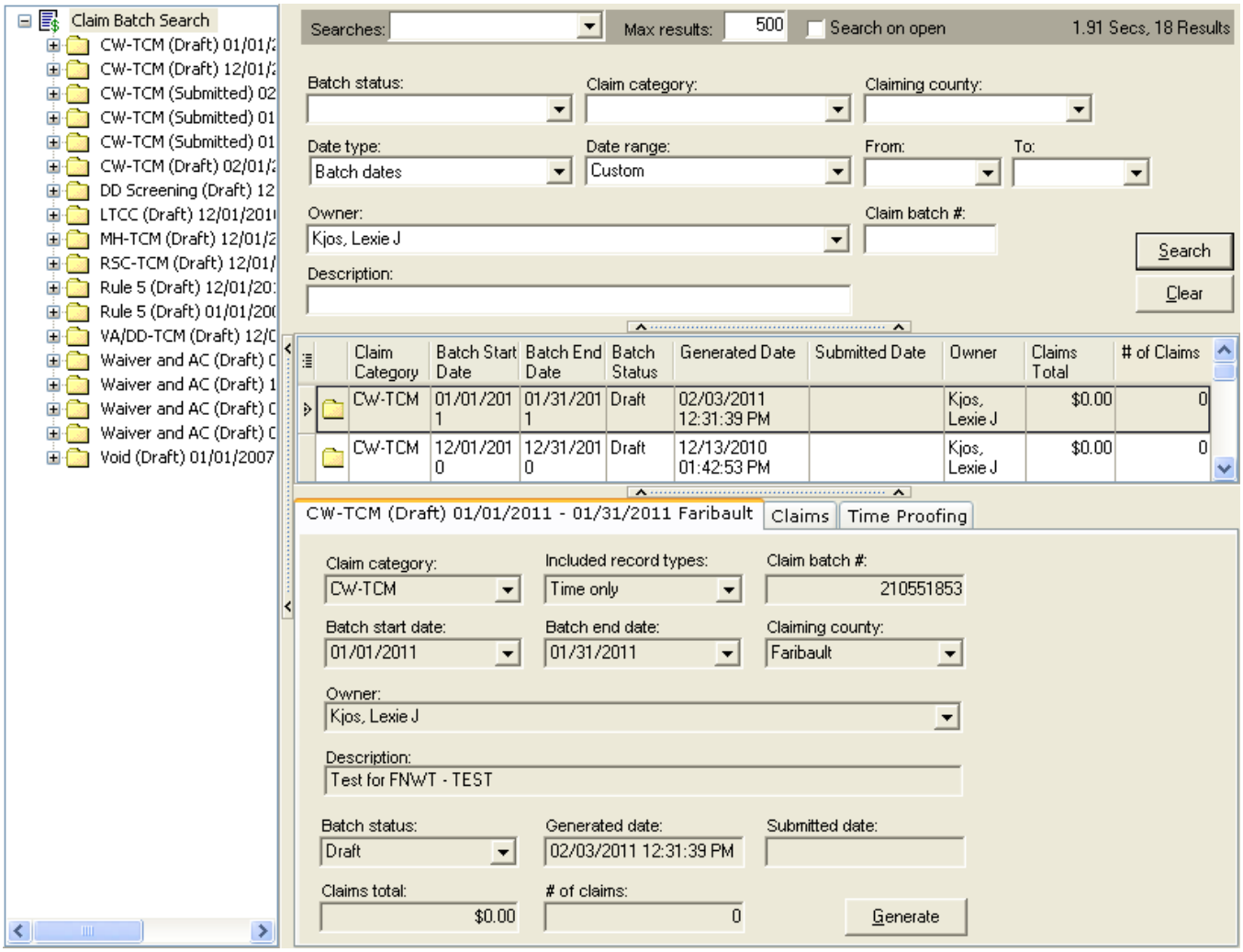
MMIS Claiming Requirements

Claim Batch



MMIS Claiming Requirements

The DHS policy group for the individual claim categories determines the specific billing rules for each claim category. Sources of requirements include Bulletins, provider manuals, memos and emails. The table below details the general requirements that apply to all claims.

(Table 2-3 in Healthcare Claiming Requirements Spec)

MMIS Claiming Requirements
General
Counties must file all claims within one year of the date of service. MMIS will deny claims for services more than one year old, as of the Service date.
Time records and Payments can only be paid by MMIS once. That is, counties cannot submit a claim for services provided under more than one claim category, or more than one HCPCS. If a claim for Time record or Payment is denied, the information in SSIS and/or MMIS can be corrected, and the claim can be resubmitted under the same claim category and HCPCS, or using a different claim category and HCPCS, which is determined by the changes that are made. SSIS uses cross reference tables from the claims table to Payments and Time records for the records that are included on a claim. The records included on a claim are created when a claim is generated and is looked at when subsequent claims are generated to exclude those that have been claimed. In addition, for LTCC claiming and DD screening only, a cross reference to the screening document used on a claim prevents duplicate claims for a screening.
Required Client Information
Client Name
Client Address (If client does not have an address, use the county address.) SSIS checks for a physical address, then a mailing address. If neither exists, SSIS uses the county address. The address records must be in effect when the claim is generated.
Gender
PMI # (Recipient ID)
Actual Date of Birth If the client has an estimated date of birth, no claims are generated for that client.
For all age calculations, if a client has a leap year birthday: • Advance age on 2/29 in leap years. • Advance age on 3/1 in non-leap years.
Place of Service Code
Every claim must have a Place of Service code. The SSIS "Location" code is converted to a MMIS "Place of Service" code. The conversion table can be found in Section 2 of the Health Care Claiming – Requirements Spec.

MMIS Claiming Requirements
In SSIS, all Payments with a HCPCS/Modifier must have a Location. Time records with one of the following activities require a Location: • 7 Client contact • 8 Collateral contact • 15 CW-TCM eligible contact 60+ mi from county border. On Time records with any other activity, the Location is optional.
When Payments and/or Time records are combined into one claim, the SSIS Location on the first record selected is used; all others are ignored.
Units / Claim Amount
The number of Units must be a whole number. (No partial units are allowed.)
The number of Units must be greater than zero.
Claim Amount must be greater than zero.
Payments
The Amount and Units on the Payment(s), after adjustment for Payment Modifications, must be greater than zero.
The Payment Status must be "Paid"; it cannot be in a Pending status. Payment Requests with the following Payment Statuses are excluded from claiming: Draft, Pending Approval, Approved, Submitted, Suspended, and Denied. The Payment Status on Posted Payments and Payment Modifications is always "Paid."
The Payment cannot already have been claimed (with the exception of Void claims and Resubmissions). This is determined by: • The Payment has a cross reference to a claim record in SSIS.
The Original Payment for a negative Payment Modification (refund, recovery, cancellation, or adjustment reversal) cannot already have been claimed.
The Payments Service Start Date and Service End Date must be completely within the dates of one Living Arrangement record. If not, the Payment is not claimed and is included on the proofing reports. The county must split the Payment into multiple records using the standard process for creating Payment Modifications. The county can also correct the service dates using the same process.

MMIS Claiming Requirements
Counties set up as a region in SSIS (Faribault/Martin and Lincoln/Lyon/Murray) only: Each county in the region submits separate claim batches. Payments are only included on claims in a batch if "Paying County" is the "Claiming County" on the batch. "Paying County" is selected by the user when the Payment is created.
The policy areas and Bulletins define which Payments are eligible for each claim category.
Staff Activity Time records
Time recorded must be greater than zero.
The Time record cannot already have been claimed (with the exception of Void Claims and Resubmissions). This is determined by one of the following: • The "Legacy Claimed Date" on the "On Behalf Of" table has a value. • This value is sent to SSIS from the legacy system for Time records that have been claimed in the legacy system. • The Time record has a cross reference to a claim record in SSIS.
Counties set up as a region in SSIS (Faribault/Martin and Lincoln/Lyon/Murray) only: Each county in the region submits separate claim batches. Time records are only included on claims in a batch if "County of Service" is the "Claiming County" on the batch. The system sets the "County of Service" to the Workgroup's "County of Service" when the Time record is created.
The policy areas and Bulletins define which Time records are eligible for each claim category.
Staff Worker Claiming Requirements
Staff eligibility requirements for each claim category are defined by policy/Bulletins. Staff claiming eligibility is determined by the county based on these requirements.
SSIS requires the county to record which staff are eligible to claim for each claim category and the effective dates of eligibility. Staff creates Qualifications for each user in the SSIS Administration application.
To claim a Time record, the Worker on the Time record must have Staff Claim Qualifications for the claim category for the date on the Time record.
The requirements sections for the individual claim categories may include additional edits regarding staff requirements, such as state staff vs. county staff.

MMIS Claiming Requirements

HCPCS/Modifier Information

The term "HCPCS/Modifiers" is used in SSIS and throughout this document referring to a valid procedure code, or HCPCS, with 0 to 4 Modifiers. Some HCPCS do not have any Modifiers; others have one, two, three, or four Modifiers.

SSIS maintains tables of valid HCPCS and Modifiers along with the effective dates, a description of each HCPCS/Modifiers combination and the unit type.

Each claim must have a "HCPCS/Modifier," which must be valid on the date of service.

HCPCS/Modifiers Rate Information

For claims based on Time records, SSIS calculates the county's cost of providing a service using HCPCS/Modifiers Staff-provided Rates stored in SSIS. Claims based on Payments use the actual rate and amount paid to the vendor.

DHS determines the maximum rate that MMIS will pay for some services. The rate may be set per county, as in the case of targeted case management services, or may be a maximum for all counties. DHS provides a reference file for other services.

The rate the county records on the HCPCS/Modifiers Rate table should be the county's actual cost for providing the services. MMIS may reduce the amount to pay according to their maximums.

SSIS requires the county to enter a rate and effective dates for each HCPCS/Modifier for claims based on Time records.

- The county Staff Provided Rate for the HCPCS/Modifiers must be greater than zero.
- The county Staff Provided Rate for the HCPCS/Modifiers must be effective on the Service Dates.

Counties can enter a waiver type in the Claim Detail field of the Staff Provided Rate record. If this field has a value, it must match the client's waiver type.

Supplemental Eligibility

Most claim categories require entry of some eligibility and/or miscellaneous information in SSIS. This information is in addition to the client's eligibility information in MMIS.

Supplemental Eligibility requirements for each claim category are derived from policy/Bulletins.

Counties have the option to set a "Do Not Claim" indicator for a client for a particular claim category during a date range. SSIS excludes records for these clients during the claiming process.

MMIS Claiming Requirements
MMIS Recipient Information
Each county receives a nightly extract from the Data Warehouse containing Recipient Eligibility spans, Service Agreements, DD Screenings, and LTC Screenings for clients cleared to that county. The data warehouse receives updates from MMIS nightly. The recipient eligibility spans contain information about the major program, eligibility type, and waiver type for which the client is eligible. Each claim category uses specific information received from MMIS in the SSIS claim edits to minimize the number of claims that MMIS rejects.

Diagnosis Codes

Diagnosis codes are required for some claim categories. Others do not require them, but one is included on the claim if one is available. Diagnosis codes come from a DD screening, an LTC screening or from diagnosis codes entered in SSIS.

The following table defines for each claim category whether a diagnosis code is required and is included on claims, and what is the source of the diagnosis.

(Table 2-5 in Healthcare Claiming Requirements Spec.)

Claim Category	Diagnosis Required?	Diagnosis included on claim	Source, in order of precedence
CW-TCM	No	No	
DD Screening	No	If available	Screening Document SSIS Diagnosis Code
MH-TCM	Yes	Yes	SSIS Diagnosis Code
VA/DD-TCM	No	If available	Screening Document SSIS Diagnosis Code
Waiver and AC	Based on individual HCPCS/Modifiers	Yes if required Otherwise included if available	Screening Document SSIS Diagnosis Code
Rule 5	Yes	Yes	SSIS Diagnosis Code
RSC-TCM	No	If available	Screening Document SSIS Diagnosis Code
LTCC	Yes	Yes	Screening Document SSIS Diagnosis Code

Proofing

Common proofing messages are used by more than one claim category. Each category has its own proofing messages and requirements in addition to these common proofing messages.

Only the owner of a batch can view claims proofing messages. If multiple staff work to resolve proofing messages, each staff person could have his/her own batch, or the owner of the batch would Save the batch and not click the Generate button. This way no claims are created/associated to the batch, but the proofing tabs are available. The owner of the batch will need to be changed to the staff person doing the review.

Example 1:

- Staff person 1 is responsible for the resolution of Time Proofing messages.
- Staff person 2 is responsible for Payment Proofing messages.
- Both should create a batch and correct proofing.
- At the point that both staff are ready to submit the claims, one batch is deleted and the remaining batch regenerated to gather all the claims.

Example 2:

- Staff person 1 is responsible to resolve all the Duplicate claim, MA eligibility and Supplemental Eligibility error/warnings for both Time and Payments.
- Staff person 2 is responsible for the remaining error/warnings.
- Both should create a batch and correct proofing.
    - Depending on the scope of proofing being done, or the role of the person doing the proofing, all or some of the Proofing check boxes can be selected to view claims not being generated because of possible data error/warnings.
- At the point that both staff are ready to submit the claims, one batch is deleted and the remaining batch regenerated to gather all the claims.

 *Hint: The staff member (fiscal, social worker, etc.) who completes any changes needed in MMIS will vary by agency. Social work and fiscal staff may need to coordinate changes with MAXIS/MMIS workers in the agency. Any changes need to resolve messages related to MMIS or MAXIS must be done in MAXIS or MMIS.*

Depending on the scope of proofing being done, or the role of the person doing the proofing, all or some of the Proofing check boxes can be selected to view claims not being generated because of possible data error/warnings.